Healthy Aging:
New Directions for Care

Part Two:
Listening & Learning

November 1999

Long Term Care Review:
Final Report of the Policy Advisory Committee

Alberta
HEALTH AND WELLNESS

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This icon shows two hands reaching out in a gesture of support and caring. Not only does this gesture represent our concern for each other, but it also represents a handshake and therefore commitment. The white space between the hands forms an "H" in reference to the title of this publication, *Healthy Aging*.

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Introduction

This is Part Two of a package of three reports from the Policy Advisory Committee for the Long Term Care Review. Part One provided an overview of the Committee's proposals for new directions for continuing care in Alberta as well as highlights of key recommendations. Part Two provides a summary of the review process and highlights of what the Committee heard and learned through extensive consultations over the last two years. Part Three of this report provides the details of the various recommendations developed by the Committee. The Committee would like to thank the hundreds of Albertans who participated in the process and the many experts who offered their views on what needs to be done to improve continuing care in the future.

The review process

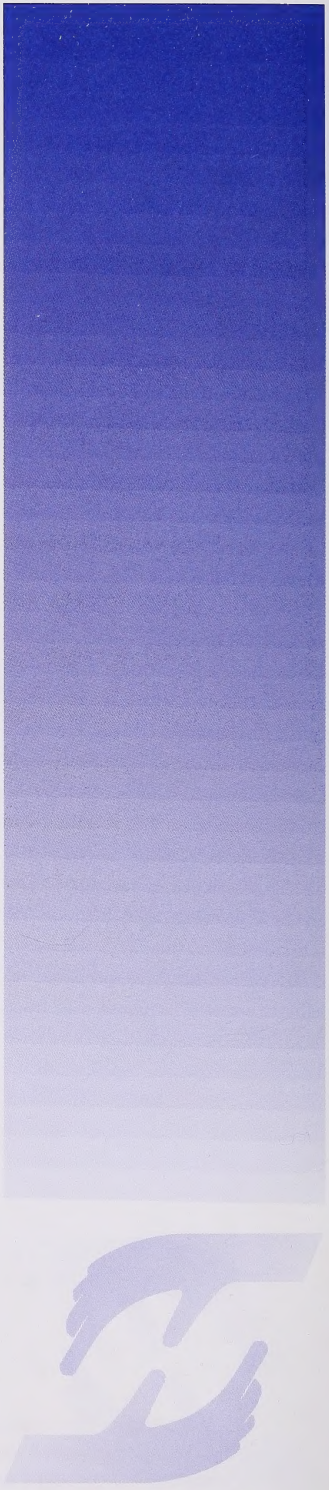
In the two years since the Committee was established, extensive work has been done to understand trends both here and around the world, consult with a variety of people, and develop scenarios for the future.

Specifically, the Committee took the following steps as part of its review:

Phase 1

During Phase 1, the Committee:

- Reviewed background information and literature on the continuing care system and the health care environment
- Conducted a survey of continuing care services across the province
- Consulted with Alberta's health authorities
- Met with people in Alberta Health and Wellness and regional health authorities responsible for implementing new models in continuing care



- Worked with the Joint Alberta Health - Regional Health Authority Committee to address home care, subsidization issues, accommodation policies, drug strategies, and medication in lodges.

Phase 2

Work in Phase 2 included:

- **Consulting with provincial organizations**
  The Committee met with 25 provincial organizations with expertise in continuing care. Organizations were asked to respond to a questionnaire focusing on four areas:
  - Healthy aging
  - Acute care and acute geriatric care
  - Community supports and care including home care, and
  - Supportive living and continuing care centres.

- **Consulting with the public**
  Consultations were held in February and March 1999 to gather the views of interested Albertans. In addition to written submissions, community meetings were arranged by Community Health Councils. The response was enthusiastic. Over 1700 individuals participated in 55 meetings, briefs were received from 27 organizations, and another 42 submissions were received from other individuals and organizations. A report titled *Summary of Consultations with Public, November 1998 to March 1999* is available and provides highlights of the views and suggestions received through this extensive process.

- **Consulting with experts**
  Three consultation sessions were held with 14 selected experts, people recognized as leaders in the long term care system from Alberta, Canada and other parts of the world. The three sessions focused on: acute care, acute geriatric services and primary care; health promotion, prevention and community support and care; and supportive housing and institutional long term care services. A proceedings document called *Summary of Consultations with Experts,*

January to March, 1999 has also been prepared and includes a wealth of information and ideas about long term care in Alberta, across Canada and around the world.

- **Developing a vision**

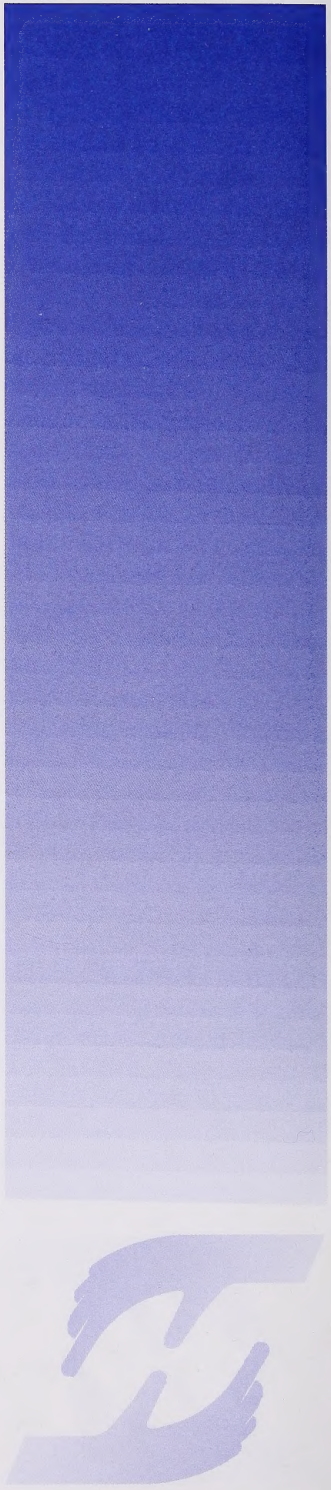
  As a starting point for setting a new direction and developing specific recommendations, the Committee developed a broad vision of aging for Albertans in the 21st century and a set of principles to guide future decisions.

- **Considering future scenarios**

  In November 1998, the Committee contracted a consultant to conduct a special study to develop future scenarios to address and forecast the continuing care service needs in Alberta to the year 2016. The scenarios were developed based on approaches taken in other provinces and countries and a survey of best practices. Focus groups were held with representatives of academic institutions, government departments and regional health authorities. In June 1999, a provincial workshop with 140 participants representing regional health authorities, provincial government departments and provincial organizations was held to review four scenarios and provide advice on which scenario best describes the future direction Alberta's continuing care system should take. The results of the June session and a report called *Future Scenarios: Continuing Care Service Needs in Alberta* are available.

- **Developing recommendations**

  Based on the wealth of ideas and advice received, the Committee considered the various steps that need to be taken to achieve the vision we set and to prepare Alberta's continuing care system for the future impact of an aging population. Part Three of this package provides the details of the various recommendations developed by the Committee.



How are services provided today?

It's important to begin with a look at where we're at today and how long term care services are provided across the province.

What kinds of services are provided?

Home care

- Home care services typically include professional services such as assessment and case coordination, nursing, physiotherapy, occupational therapy and nutritional therapy, and support services such as homemaking and personal care services. Eligibility for home care services is based on a needs assessment.
- In 1997-98, there were 71,045 Albertans receiving home care services. That is a significant increase from 1993-94 when just under 53,500 people received home care services.
- The total number of home care hours per 1,000 population increased by 29% between 1994-95 and 1996-97.
- Since 1993-94, the number of hours for professional services rose by 52% and personal care hours increased by 196%.
- For 1997-98, 71.5% of home care clients were 65 years of age and older. For every 1,000 people who are over 85, 465 were receiving home care services compared with only 61 out of 1,000 people aged 65 to 69.
- For long term home care, the average number of home care hours per month tends to be highest for people aged 20 – 40 years then declines for people over 65.

Medications

- In 1997-98, there were close to 196,000 seniors registered for drug benefits under Alberta Blue Cross.
- The total number of prescriptions was over 5.3 million – an average of 27.1 prescriptions per person per year.
- The total cost of these prescriptions was $146.4 million and the average payment per person was $747.16.

Seniors registered with Alberta Blue Cross have an average of 27.1 prescriptions per person per year.

Use of the health care system

- Looking at the costs of a range of health services provided in the province, services for people 65 years of age and older make up just over 43% of the total costs compared with about 57% for all other age groups. For services by regional health authorities, services to people over 65 make up about 48% of the costs. People over 65 account for just over 24% of the cost of health practitioner services, almost 83% of Alberta Blue Cross services, and about 61% of the costs of aids to daily living services.

Table 1

1997- 98 Health Services Expenditures
Estimated Allocation by Age Group

Age	Services by RHAs	Practioner Services	Blue Cross	Aids to Daily Living	Other Programs	Total
0-64	52.2%	75.8%	17.1%	39.2%	75.8%	56.5%
65+	47.8%	24.2%	82.9%	60.8%	24.2%	43.5%
Total ($'000)	$2,618	$903	$196	$54	$131	$3,901

Source: Alberta Health and Wellness

- In 1997-98, 44.8% of all patient days in hospitals were for the care and treatment of people 65 years of age and older.
- Older people also tend to stay longer in hospital. For people 75 years of age and older, the average length of stay is 12.6 days compared with 5.2 days for people under 65.
- Almost 94% of the people in long term care facilities are 65 years of age and older.

Table 2

Number of Acute Care Patient Days By Age Group: 1995-96, 1996-97 and 1997-98						
Age Group	1995-96		1996-97		1997-98	
	#	%	#	%	#	%
0 - 64	1,264,575	54.7	1,280,916	57.1	1,278,798	55.2
65 - 74	385,529	16.7	341,167	15.2	370,117	16.0
75+	663,099	28.7	619,751	27.6	667,180	28.8
Total	**2,313,203**		**2,241,834**		**2,316,095**	

Source: Alberta Health and Wellness, Information to Support Health Authority Business Plan and Annual Report Requirements, December 1998 Acute Care Tables F2A and F2B

Table 3

Average Length of Stay in Acute Care Hospitals By Age Group: 1995-96, 1996-97 and 1997-98			
Age Group	1995-96	1996-97	1996-97
0-64 Years	5.0	5.2	5.2
65-74 Years	10.2	9.0	9.7
75+ Years	13.6	12.2	12.6
85+ Years	12.1	10.8	11.4
Total	6.8	6.7	11.4

Source: Alberta Health and Wellness, Information to Support Health Authority Business Plan and Annual Requirements 1999-2000 to 2001-2002, December 1998 Acute Care Tables F2A and F2B

Table 4

Age Distribution of Clients for Health Services in 1997-98						
Age	Home Care Clients		Long Term Care Facilities/ Residents Care		Hospital Patient Days	
0-64	19,047	28.5%	841	6.5%	1,278,798	55.2%
65+	47,834	71.5%	12,003	93.5%	1,037,297	44.8%
Total	66,881	100.0%	12,844	100.0%	2,316,095	100.0%

Source: Alberta Health and Wellness

What kinds of housing are available?

Living at home

By far, the majority of elderly Albertans live in their own homes, and that's exactly where they want to stay, for as long as possible. This trend of seniors staying in their own homes as long as possible is expected to increase.

Home care services are provided to people who need support in their homes. This includes short term home care, long term home care and palliative care.

Supportive housing units

Supportive housing units are a relatively new development in Alberta. Alberta has 15,859 supportive housing spaces, including 7,287 lodge spaces. The majority of supportive housing spaces are located in Edmonton and Calgary.

Supportive housing units include a variety of group living arrangements in different types of housing alternatives including condominiums, apartments and group homes. The concept behind supportive housing units is to provide not only housing but also a range of services to meet the needs of individual clients. For those with higher needs, assisted living arrangements provide a special combination of housing, personalized supportive services, food services, pharmacy services, and health care. For those with lower needs, supportive housing provides services that are more limited to managing the property and providing specific housekeeping services rather than including personal care management or health services.

Home care services are usually provided on an individual basis in supportive living units. This can include professional services like nursing, physiotherapy, occupational therapy services, as well as services from social workers and a variety of other professionals. It also can include personal care services and home-making services.

Home care services provided in supportive housing units are supported by regional health authorities. In some cases, the regional health authority provides block funding to the supportive living site to cover the costs of home care. In other cases, they contract with supportive living operators to coordinate health and housing services.

Alberta has a lodge system which is unique in Canada. Lodges are a form of supportive living. Their services vary but typically include housing and meal services. About 50% of lodge residents currently receive home care and require assistance with mobility. About 32% receive assistance with medications and 5% require oxygen.

The development of supportive housing arrangements is a new phenomenon in Alberta and it is growing significantly. Compared with other provinces with older populations, Alberta has fewer supportive housing spaces, and the variety of models and sites is not as extensive. Most are located in Edmonton and Calgary. Currently, there are no consistent standards or legislation covering supportive living units.

Supportive housing units are usually built by the private and voluntary sectors, and then either purchased or rented by the individual client.

More older adults are opting for supportive housing arrangements because of their flexibility and the options they provide for adding services as people age. This flexibility allows people to "age in place" without having to leave their homes in order to access additional services.

Long term care centres

Long term care centres include nursing homes, auxiliary hospitals and other centres that provide 24 hour professional and personal support services. People in long term care centres have greater physical and cognitive needs, and depend on the support of staff for help with their daily activities.

Typically, services are provided by doctors, registered nurses, licensed practical nurses, physical therapists, occupational and recreational therapists, pharmacists, dieticians, social workers, personal care aides, and others. The ownership of long term care centres varies and includes regional health authorities, private operators and voluntary operators.

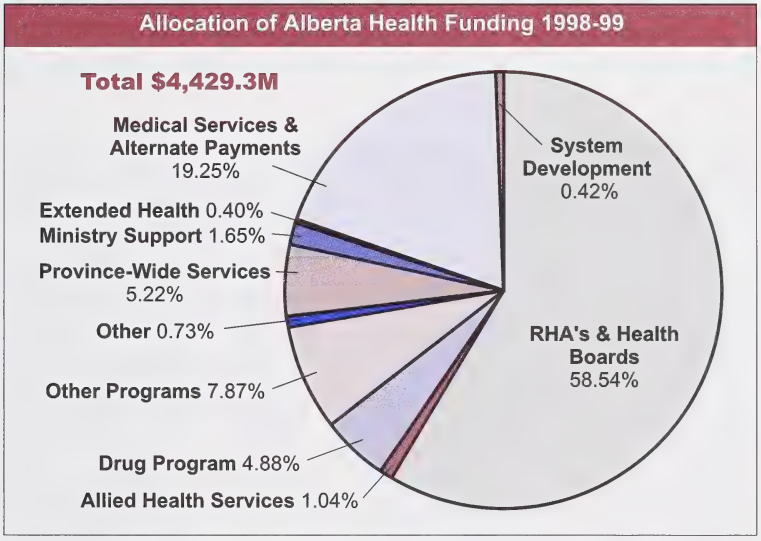
Here is some current information about Alberta's long term care centres:

- As of March 1998, Alberta had 12,880 traditional long term care beds, 180 specialized beds, 180 long term care beds converted from active treatment beds, and 178 sub-acute beds.
- A February 1998 survey showed that 12,844 individuals lived in long term care centres in Alberta. While there are some younger people living in long term care centres, about 94% of the residents are 65 years of age or older.
- Studies have shown that people living in long term care centres tend to be more seriously ill than in the past. This is due to a combination of factors including longer life span and more people with lower care needs being served in their homes and communities.
- The utilization rate for long term care centres has fallen from about 105 per 1,000 people over 75 years old in 1988 to 86 per 1,000 people over 75 in 1997 – a decrease of 18% over a nine year period.
- The current supply of long term care beds in Alberta has been in use for more than twenty years and extensive renovation, replacement and upgrading are needed. The average capital cost for building a new long term care bed ranges from $120,000 to $250,000 depending on the design and location of the facility. The average operating cost is $105 per person per day.

How are health and continuing care services funded?

In 1998-99, the total budget for health services in Alberta is just under $4.5 billion. The figure on this page show the breakdown of the proportion of that total amount that goes to support different categories of health services.

Figure 1



Source: Alberta Health and Wellness, Health Resourcing Branch, September 1999

In the past, health care funding was directed to specific facilities, agencies or programs. Beginning in 1997-98, a new funding approach was adopted. Now, regional health authorities receive most of their funding through a population based funding formula that takes into account:

- Total population in the region
- Age and gender composition of the population
- Socio-economic composition of the population
- Services provided to people in other regions.

In addition to the population-based funding, a number of services are designated as "province-wide services" and are funded separately. These high-cost, high-tech, life-sustaining services are delivered primarily in Edmonton and Calgary but are available to all Albertans.

Regional health authorities are responsible for providing support for continuing care services in their region. This includes funding home care services, community programs, and health-related services in long term care centres.

Regional health authorities are responsible for supporting all professional components of home care. Albertans of all ages are eligible for professional and support services from home care up to a maximum of $3,000 per month. That includes assessment, case coordination, direct professional and personal care services. A fee of $5 per hour, to a maximum of $300 per month, is charged for homemaking services based on a sliding fee schedule for individual and family income. There are some inconsistencies across the province in terms of access to and charges for homemaking and personal care services.

Funding provided from regional health authorities to long term care centres is based on a resident classification system and a case mix index, however, there are inconsistencies across the province. In terms of capital costs for new long term care centres, the provincial government provides capital grants for a limited number of projects that are submitted by regional health authorities.

Residents of long term care centres pay for the partial costs of their room and board services but not for their health care services. Accommodation charges partially cover the costs of food, housekeeping and other related costs but do not cover the rental (capital) costs of the room. The current accommodation charge is $24.65 a day for a standard room with up to four people, $26.25 a day for a semi-private room, and $28.60 for a private room. These charges have not been increased since 1994 and are among the lowest of the ten provinces. Alberta is the only province in Canada that does not have an income test for accommodation charges.

Table 5

Interprovincial/Territorial Comparison of Long Term Care Accommodation Charges as of September 1999

Province/ Territory	Accommodation Minimum (Daily)	Accommodation Maximum (Daily)	Income Test	Asset Test
Yukon (1998)	$18.00	$18.00	No	No
N.W.T.	$23.41	$23.41	No	No
Alberta	$24.75	$28.60	No	No
Saskatchewan (10/99)	$25.87	$33.63	Yes	No
British Columbia	$25.30	$50.00	Yes	No
Quebec	0	$42.89	Yes	Yes
Manitoba	$25.10	$41.56	Yes	No
Ontario	0	$107.00	Yes	No
P.E.I.*	$30.00	$93.33	Yes	Yes
Newfoundland (1998)	$93.33	$93.33	Yes	Yes
Nova Scotia**	$85.72	$147.21	Yes	Yes
New Brunswick***	0	$130.00	Yes	Yes

* Refers to government subsidized facilities only.
** Includes care and supplies funding component. Does not include government subsidy.
*** Includes care and supplies funding component.

Source: Alberta Health and Wellness, Updated September 1999

A look at the trends

The Committee reviewed extensive information about trends here in Alberta, across Canada and around the world. Much of that information is included in the report on *Future Scenarios: Continuing Care Service Needs in Alberta* and in the *Summary of Consultations with Experts, January to March, 1999.*

What are the significant trends in continuing care?

The Committee reviewed the leading trends and developments in the Netherlands, Denmark, Sweden, Australia, the United States and other provinces across Canada. The following are highlights of those trends.

- There is an increasing focus on home living options, where services are available 24 hours a day and homes are adapted to support the needs of residents as they age. One example is "grow-along houses" in the Netherlands.
- There is a declining focus on building institutions. People are only admitted to facilities when the costs of supporting them in their own homes become prohibitive. In Denmark, a moratorium on building new facilities was declared combined with major incentives to encourage alternative living arrangements in the community.
- Health, social services and housing services are being delinked or "unbundled." This allows people to choose the types of health and social services they need regardless of their housing arrangements. In the past, the type of health and social services depended on the particular housing arrangement involved.
- More funding is going directly to individuals and moving with them to where they live. This gives people more choice in the services they want and need. In the past, funding was provided to the facility or to those providing the service. In the Netherlands, for example, people are provided with personalized care budgets and can then choose the services they need.

- There is an increasing array of community service providers in both the public and private sector. This introduces an element of competition and increases the focus on quality of service provided. It also increases the range of choices available to the individual.
- There is an increasing reliance on the private sector for the housing component. In some places, particularly Sweden, the private sector is also expanding into providing health and social services.

What are the current benchmarks for continuing care services?

It is important to look at the types of guidelines, utilization patterns and standards in place in other provinces and selected countries. Through a separate benchmarking study, the Committee learned that:

- All provinces offer continuing care services in three streams – facility based, supportive living, and home living. The terminology varies widely from province to province, especially in the facilities sector. Of the three streams, increasing attention is being focused on the home living and supportive living streams. The supportive living stream is the least developed and is an area of growing demand.

- Eligibility criteria and service guidelines for the home living stream are fairly similar across Canada. All have age and residency requirements. Most have limits on the maximum amount of home care provided. When the maximum is reached, the individual is reassessed for referral to a continuing care centre.

- All provinces provide a standard package of professional and support services using a variety of service providers. The types of services included in the standard package vary among the provinces.

- Most provinces have delegated delivery of services to regional health bodies. Approaches to delivering services

vary across the country. There is a growing involvement of the private sector and the voluntary sector in providing support services, institutional care and other housing arrangements through contract arrangements with the public sector. In some provinces, the private and voluntary sectors are involved in delivering some professional health services, e.g. Victorian Order of Nurses. Housing alternatives and related services are provided through a variety of government departments, often separate from the health department, and delivered through municipal governments or other housing authorities. Internationally, municipal governments may play a role in the delivery of all health and social support services, as well as housing.

- All provinces have developed streamlined assessment procedures and some form of classification system, although the approaches vary across the country. Several provinces are in the process of upgrading their assessment and classification systems. Case/care management services are also provided in all provinces.

- Across Canada, professional services are provided at no cost to the client. Fees are typically charged for support and housing services. The fees are income and, in some cases, asset tested. The amount of fees to be paid by the client is capped. Internationally, clients are given the option of purchasing additional services beyond their assessed needs if they want to pay for them.

- Respite for caregivers is available in most provinces and includes day and night programs either in a community setting or an institutional setting. Most provinces do not have provisions for reimbursing family members who are extensively involved in the care of their family members.

- Planning approaches, information systems and databases are in different stages of development across Canada. Consequently, bed and service planning guidelines and specific utilization rates are largely unavailable.

What do we know about the impact of an aging population?

In recent years, there has been more discussion of the fact that Alberta's population, and the population of Canada as a whole, is aging. A number of national and international studies have looked at the impact of an aging population on health care services. Some studies tend to focus on the negative impact of a demographic shift, calling an aging population a potential "crisis." Other studies tend to downplay the potential impact.

As part of its review, the Committee reviewed Alberta information and a number of studies and reports. As noted earlier, evidence suggests that, while the majority of people stay healthy as they age, older people do tend to use more health services. If older people develop complex, chronic health problems, they depend more on the health care system.

For this reason, the Committee believes that an aging population will have an impact on the health system. However, with new approaches and appropriate planning, an aging population is not a potential crisis for the health system. The use of health services is affected by many different factors including health status, how services are delivered, availability of alternatives and the practice of health professionals. New approaches to promote healthy aging, combined with different ways of delivering services, can have a positive affect on how an aging population uses the health system in the future.

The Committee believes it is important to consider the trends, set new directions and begin planning for the future. An aging population should not be seen as a burden, but as an opportunity to improve the system and expand the choices available for people to stay healthy and independent as long as possible. The Committee also supports the work of the Government-Wide Study of the Impact of the Aging Population. Many of the recommendations included in Part Three of this report point to areas where we can anticipate future demands on the health system and put new approaches in place to respond to changing needs of an aging population.

"An aging population should not be seen as a burden, but as an opportunity."

Policy Advisory Committee

"The aging of the population will not have as dire consequences for the health system as some forecast. Nonetheless, it is important that the province increases the pace of innovation to ensure that primary health care is strengthened. Without a proper system of primary health care, the province's elderly will suffer needless health problems and there will be increasing pressure on the province's institutional system."

Dr. Michael Rachlis

A profile of Alberta's seniors – today and tomorrow

What do we know about Alberta's seniors today? The first report of the Government-Wide Study of the Impact of the Aging Population contains some interesting facts.

- 9.8% of Alberta's population is over 65 years of age. Across Canada, roughly 12% of all Canadians are over 65.
- This year, an estimated 20,000 Albertans will turn 65 and become seniors.
- The largest group of seniors is under the age of 75.
- Over 54% of seniors are married and almost 33% are widowed. Over 40% of women over 65 are widows.
- About 68% of seniors live in their own homes and an additional 19% live in self-contained rental accommodations. About 60% of seniors live in communities with populations over 100,000.
- As seniors age, the probability of living alone increases.
- Over the past 15 years, the incomes of seniors have risen faster than incomes of people under the age of 65. In 1995, the annual before tax income of a single senior in Alberta was $23,467 on average, with a median income of $16,000. Senior families have a much higher income, about twice as much on average.
- According to Statistics Canada, 23% of all people 65 and older were involved in unpaid volunteer activities in 1997. In addition, one quarter of Canadian seniors provided unpaid care or assistance to other seniors. Eighty-five percent made financial donations to charities on top of their volunteer activities. Seniors also contribute income and property tax dollars.

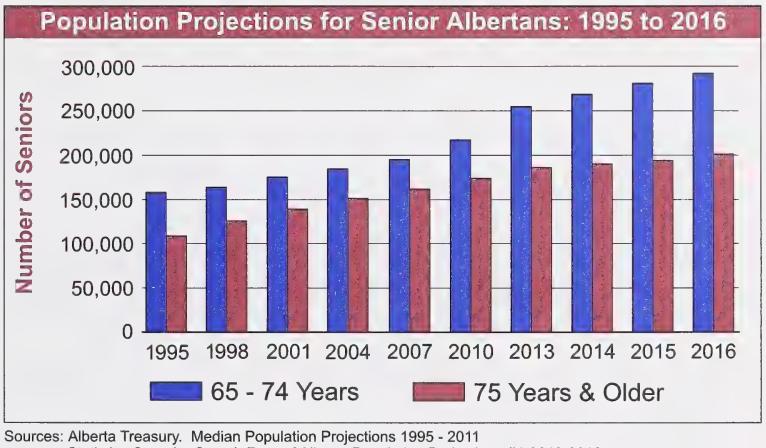
- Over 40% of Alberta's seniors rate their health status as very good or excellent. About the same percentage say that they have chronic health problems.
- The most common health conditions and disabilities affecting seniors are conditions like arthritis, hearing loss, back problems and cataracts. These conditions affect quality of life but are not life threatening.
- Dementia, including Alzheimer's disease, is a condition commonly associated with age. While most seniors do not have dementia, the incidence increases with age. According to the Canadian Study on Health and Aging, 8% of all Canadians aged 65 and over met the criteria for dementia. The incidence is 34.5% for people over 85 years.

Looking ahead, what trends do we anticipate?

- The proportion of seniors is expected to grow to 14.5% by 2016. While Alberta's overall population is expected to grow by 35% by 2016, the number of people over 85 is expected to grow by 4.1% and the number of people over 75 – the main users of continuing care – is expected to grow by 65%.
- By 2016, we expect Alberta's senior population to be characterized by:
  - More education – resulting in more informed consumers with increased demands for options and choice, and the ability to manage their own care.
  - More income – resulting in an increased willingness to pay for the care and living options they want. The portion of low income seniors will be less but will still require subsidy programs to meet their needs.
  - Improved health – resulting in more independence and increased demands for a range of care and living options.
  - Accommodation apart from extended family – resulting in increased demands for housing alternatives and increasing expectations for workplaces to provide elder care benefits for working family members.

- Accommodation at home – resulting in increasing demand for choice, service options and flexibility, as well as adaptations to their homes so people can "age in place."
- More active lifestyles – influencing the types of recreational and social programs desired, and the ways and means of readily accessing them.
- More technological capabilities – strengthening the use of technological aids in the home and enhancing the ability for people to manage their own care.

Figure 2



Sources: Alberta Treasury. Median Population Projections 1995 - 2011
Statistics Canada, Growth Rate of Alberta Population Projections #4-2012-2016

Listening to Albertans

A key component of the work of the Committee involved listening to the views of Albertans. Albertans were asked for their views in six key areas:

- Healthy aging
- Acute care services, acute geriatrics and drug utilization
- Community support and care services
- Supportive living and services
- Long term care centres
- Financial accountability

These are the highlights of what Albertans had to say.

- **Overall, Albertans are passionate about their health system and they know their values.**

  People expect action to address issues in continuing care. They expect the health system to help them enjoy a high quality of living and independence as they grow older. They want to remain in their own homes and their own communities as long as possible, and to be able to remain together as a couple as long as possible. They want a sense of control and responsibility for their well-being, including the right to take a risk and manage their own care. They want choices and the information they need to make informed choices. They want an expert and responsive health system that focuses on their needs. They want a health system where consumers, policy makers and providers work together to provide a coordinated continuum of services. And they want equity in access to health services across the province.

▸ Keeping people healthy is the first step.

People said that promoting healthy living is an important first step in preparing for healthy aging. Specifically, they suggested that:

- Programs and services should be in place to enable healthy living.
- The nutritional needs of seniors should be addressed.
- Education is needed to change attitudes and encourage people to adopt healthy living patterns.
- Research on healthy aging and sustaining quality of life is needed.
- Retirement may need to be re-thought.

▸ Many aspects of acute care services for older people need improvement.

As people age, their use of the health care system increases, including use of acute care services. Changes in acute care services such as shorter lengths of stay were viewed as having adverse affects for many older people. Geriatric services are limited to major centres. The increasing number and complexity of chronic conditions, including Alzheimer's disease and other dementias, compounds the care needed and reinforces the need for specialized skills and education.

Specific suggestions include the following:

- Specialized geriatric assessment should be a priority.
- Access to specialized geriatric assessments and rehabilitation needs to be enhanced.
- Acute care beds need to be appropriately used.
- Discharge planning needs to be improved.

▸ Community support and care services need to be enhanced.

Community support and care services enable people to live in their own homes and communities. The demand for these services has increased considerably, often in excess of available resources. Concerns were expressed about the way services are delivered and the need to recognize the support provided by family members and other informal caregivers.

Specifically, the Committee heard that:

- Home care and support services need to be enhanced and there should be consistency across the province.
- Family respite services and financial incentives are a necessity.
- Transportation services are essential.
- There needs to be an adequate supply of educated, community-based staff.
- Community partnerships are essential in optimizing the potential of the community-based system.
- There should be more awareness of and information about community services.

▸ More flexible housing options need to be developed.

The adequacy, affordability and availability of housing options were identified as major issues for many older people and for people with special needs such as the disabled, those with Alzheimer's disease, people living with mental illnesses, and those with brain injuries. Inter-departmental cooperation is needed to meet these housing and health needs. Some suggested that a single ministry should be created to address seniors' issues in health, housing and community support services.

Specific policies and strategies suggested include the following:

- Multiple housing options are needed, including options like group homes with extended services, "granny" flats, and assisted living alternatives.
- Multi-level care facilities are needed.
- Lodges require enhanced services.
- Regulations and standards are required.

▸ Continuing care facilities will be managing more complex conditions.

As community care options and informal support in the home and community continue to improve, more people will choose to stay in their own homes and communities. As a result, the demands will increase for long term care centres to provide higher levels of care for people with complex conditions and greater dependencies. Concerns were expressed about whether there are enough people with the right skills in long term care centres to meet those increasingly complex needs. People also suggested that the facilities should be designed to accommodate special care needs of those with Alzheimer's disease, brain injuries and other disabilities.

Strong concerns were expressed about the need for more facility-based beds to alleviate waiting lists and reduce the demand on acute care beds. Some suggested that more facilities were required across the province to allow people to stay close to their home community. Policies such as "the first available bed" were not viewed positively.

Specific suggestions were as follows:

- More facilities are needed, including those designed to meet special care needs.
- More staffing is required, including those with higher knowledge and skill levels.
- Existing facilities need upgrading.

▸ Multiple financial and funding approaches are suggested.

Financial responsibility was viewed as a shared responsibility among individuals and their families, provincial and federal governments. There were overall suggestions that more money was needed to support the continuing care system and address a variety of needs, but others noted the need for funding constraints and the importance of setting priorities. The need for accountability and measuring performance was also reinforced.

Specific funding approaches suggested included the following:

- User pay approaches need to continue and, in some cases, increase. Older persons should have the option of paying for higher levels of services if they wish and daily rates in continuing care facilities should be increased. Accommodation costs should be the responsibility of the individual while the government is responsible for health care costs.
- Establish new funding models and cost control frameworks. Population-based funding was supported, but funds available have to be consistent and sufficient to meet the increasing needs of people in continuing care centres. Funding approaches for physicians should be reviewed to encourage physicians to take the additional time needed to care for older persons.
- Allow funds to follow the individual.
- Provide financial incentives in various forms, including incentives for staying healthy, income tax incentives for informal caregivers, and coverage for the cost of drugs and supplies used in home and community care.
- Target other sources of revenue, including using funds from savings in other areas, earmarking a portion of oil royalties, diverting interest savings, using lottery revenues, or raising funds at the local level.

▸ The role of the private sector is a special issue.

Mixed views were expressed about the role of the private sector. Some felt that the private sector has a role to play, especially in providing housing options. Some suggested that incentives should be in place to encourage developers to build private, affordable, and safe rental accommodations. On the other hand, some felt that the role of the private sector should be curtailed to avoid developing a two-tiered system. Where the private sector is involved, standards and regulations are required to ensure quality of care.

▸ Drug utilization is a major concern.

Concerns were expressed about the improper use of medications and the adverse affect they can have on the health and well-being of people as they age. The number and type of drugs being prescribed were viewed as excessive, and not enough attention is paid to alternative therapies. Overall, a drug utilization and management strategy is needed for the continuing care sector.

Specific suggestions were to:

- Reduce the number of prescription drugs being taken by older people.
- Monitor and educate people on the use of prescription drugs and other medications.
- Expand research on the effectiveness of alternative therapies.
- Conduct pharmaco-economic drug reviews.
- Reduce the high costs of drugs and other therapies.
- Review the need for pharmaceutical services in continuing care centres.
- Enhance the role of pharmacists.
- Promote the availability of medication administration programs in lodges.

▸ The physician's role needs to be addressed.

Physicians play a critical role in care for older people. Concerns were raised about the supply of and accessibility to physicians, especially those with specialized skills in geriatrics.

Specific suggestions included:

- Strengthen physicians' gerontological knowledge and skills.
- Re-examine physicians' reimbursement structure.
- Address the ongoing supply of physicians.

▸ Technology holds high potential.

Developments in technology have the potential to facilitate administration, promote efficiency and effectiveness, and improve medical treatment. Specifically, suggestions were made to:

- Explore telemedicine and telehealth initiatives.
- Develop smartcard technology.
- Increase the use of personal care and environmental aids to support independence.
- Invest appropriately in diagnostic and therapeutic technologies.
- Facilitate automated record keeping systems, allowing information to be shared across the health system.
- Optimize the use of the Internet.

▸ Ethical issues are gaining prominence.

People are living longer and, for some, that means facing more complex medical conditions. Medical technology is helping to lengthen life expectancy and the survival of people with disabilities. Combined with these developments, ethical issues such as quality of life and informed choices are gaining increased importance.

Specifically, suggestions were made to:

- Increase knowledge about personal directives.
- Streamline the processes to access guardianship and trusteeship.
- Address questions about end of life decisions and implications for health policy.

▸ Aboriginal members have special needs.

Concerns were expressed about equitable access for Aboriginal members to continuing care services and facilities, and the need for these services and facilities to be adapted to accommodate traditional practices and cultural preferences.

Specific suggestions included the following:

- Improve accessibility to long term care services and facilities for First Nations people.
- Combine traditional and modern therapies.
- Provide cultural training to staff.
- Encourage the education of Aboriginal health care professionals.

▸ Mental health services need more attention.

Older people may be subject to mental health problems such as depression, suicide, physical and emotional abuse, dementias, pre-existing chronic mental illnesses and disorders, and other chronic conditions that have an impact on mental health. Mental health services need to be available in the community to address these needs. Accessing these services is a particular problem in isolated communities such as those in northern Alberta.

Specific suggestions included:

- Encourage community acceptance and participation of those with mental illnesses.
- Increase the supply of housing options for people living with mental illnesses.
- Improve access to acute care and geriatric services for people living with mental illnesses.
- Provide specialized programs in continuing care centres.
- Strengthen bereavement support programs.

▸ Quality of care, standards and regulations need to be addressed.

Currently, components of the long term care system operate under different Acts and regulations. Suggestions were made that a new continuing care act should be put in place to govern all aspects of the long term care system, including seniors' housing.

Suggestions for improving the quality of care included:

- Strengthening provincial and local planning processes.
- Establishing benchmarks and quality indicators.
- Increasing the focus on outcomes of service.
- Developing and regularly monitoring measurable performance standards based on client-focused approaches.
- Strengthening evaluation processes and performance measurement systems, supported by appropriate information systems and technology.
- Improving funding methodologies to meet care requirements.
- Promoting partnerships involving private sector developers, non-profit operators and home care.

A complete summary of the views of Albertans on these issues is included in a separate report – *Summary of Consultations with the Public, November 1998 to March 1999*.

Listening to experts

In addition to listening to the views of Albertans, three sessions were held with panels of selected experts. Experts were invited to present papers on four specific areas:

- Healthy aging
- Acute care services and geriatric care services
- Community support and care services, including home care
- Supportive living and services

A total of fourteen experts from Alberta, other provinces and other countries attended the sessions and made presentations to the Committee. The ideas were diverse and the presentations stimulated considerable discussion, thought and debate.

It is difficult to summarize the many views and ideas that were put forward at these sessions. A complete summary of the presentations has been prepared, including the text of the presentations and the key themes from the panel discussions. A copy of the summary report titled *Summary of Consultations with Experts, January to March 1999*, is available and the Committee encourages people to review that report along with our report and recommendations.

Discussing issues

As part of the process, the Committee spent considerable time listening to Albertans, seniors, various experts, and those who work directly in seniors health and continuing care. The Committee learned that a number of new and innovative approaches are underway in regional health authorities and long term care centres across the province. We learned that family physicians, nurses, and a wide variety of health care providers are working hard to meet the needs of older people and those who need long term care.

At the same time, the Committee also heard concerns in a number of areas. The following is a summary of the key issues raised with the Committee through the various consultations and submissions.

- Acute care hospitals and medical services were developed when the population was younger. These services are not well organized or well prepared to serve an aging population.
- Acute care hospitals and medical services are organized to deal with specific diseases, not the complex, multiple health problems of elderly people, especially those who are frail. The result is that elderly people are treated for their immediate symptoms then discharged and frequently readmitted.
- Many dedicated physicians, nurses and health providers are working hard to meet the needs of elderly people, but they do not have extensive training in how to deal with the complex needs of the elderly, particularly those with cognitive problems and dementia.
- When elderly people are admitted to hospital, it often leads to lengthy stays. Strategies are needed to prevent admissions unless they are necessary and to provide other options for meeting the needs of older people.

- In spite of the best efforts of people to make it work, effective discharge planning is lacking in most hospitals and between regions. This causes problems in coordinating care for frail elderly people and those with chronic health problems.
- While home care services have been increasing, there is a growing gap between the number of people needing home care services and the resources available to provide them. With shorter lengths of stay in hospital, people requiring urgent home care are given a higher priority, leaving less funding available to support people needing long term care. There are increasing demands for home care to support the needs of an aging population and allow people to remain in their own homes.
- For people who need care and support, but would like to maintain their independence, there are not enough housing options with health services available as an alternative to moving into a long term care centre. This is especially true in rural Alberta.
- Effective coordination among the various services, health care providers and other professionals is not always in place. With increasing choices and options for individuals and their families, it will be even more important to have coordinated access to a wide range of continuing care services.
- Even in places where adequate services exist, unfortunately, there is not a good linkage between people who need the services and those who can provide them. It is not always a problem of more programs being needed, but a problem of making the right connections between the programs and services, and the people who need them.
- Currently, services are not consistent and comparable across the different health regions, particularly in home care. This means individuals in one part of the province may not have access to similar services as people in other parts of the province.

"... it always used to amaze me that if a patient were to have a cardiac arrest on the street, the whole system could be mobilized. If the patient were to fall down 20 feet and sustain multiple trauma, the whole system could be organized, but if a patient with dementia were to develop behavioral problems, the system could not be motivated to respond. It is not that it is harder to care for demented patients' behavioral problems ..."

Dr. Ken Rockwood, Professor of Medicine, Dalhousie University

- With shorter stays in hospital, patients are discharged early and, very often, they are expected to bear the additional costs of drugs and supplies that were available in hospital.
- With more people being cared for in their own homes and communities, there is increasing stress for families and caregivers.
- Accommodation charges in long term care centres are the lowest among the ten provinces and have not increased since 1994. The charges are sometimes lower than the rental payment of the housing units. This creates an incentive for people to use a long term care centre rather than remaining in their own homes or other supportive housing arrangements.

Considering future scenarios

One of the important steps in developing recommendations for the future is to consider a range of possible scenarios and to make judgements about which is the best fit for Alberta. To assist in this process, the Committee contracted a consultant. Based on their review of the literature, trends across Canada and around the world, and a benchmarking study, four scenarios were developed.

The scenarios envision people being served in three different streams – the home living stream, the supportive housing stream, and the facility-based stream.

In the **home living stream**, people would remain in their own homes. Typically, people with fewer health care needs and a greater ability to remain independent would choose to stay in their own homes as long as possible. Case and care management would be provided to coordinate an array of professional and support services. Informal support would be provided by families and friends.

The **supportive living stream** involves different types of group living arrangements. Services available in these housing alternatives would vary by the type of housing arrangement and would be "unbundled" from the housing component. That means people could choose from a range of services to meet their needs rather than have a set package of combined housing, professional and support services. The types of supportive housing arrangements would vary from assisted living units where housing is combined with personalized support services and health care services, to supportive housing where only property management and some housekeeping would be available. The supportive living stream allows people to "age in place" and have access to a range of services depending on their needs.

The **facility-based stream** will continue as a system of long term care centres across the province. These centres will provide 24 hour professional and personal support services

to people with high physical and cognitive needs and dependencies. Ownership of the centres will continue to include the public, private and voluntary sectors. With other living arrangements in place, the demand for facility-based care is expected to stabilize over time.

Appendix 1 provides more detailed information on the features of each of the three streams.

Looking at current utilization rates and demands for services, and trends in Alberta and around the world, four alternative scenarios for the future were developed.

Base scenario – This is essentially a continuation of the status quo. There would be a slight decline in the use of long term care centres as a result of improved health, higher income and the demand for alternatives such as remaining at home or moving into supportive living arrangements. Projections are for the utilization rate in facilities to decline by about 11% by 2016 but there would continue to be a demand for continuing care beds.

Scenario 1 – Under this scenario, there would be only slight changes from the current situation. More people would choose to live in alternative living arrangements rather than moving to or remaining in long term care centres.

Scenario 2 – This scenario would see a moderate or medium shift from the current situation, with fewer people living in facilities and more people living in alternative arrangements such as supportive living or remaining at home with home and community support.

Scenario 3 – Under this scenario, there would be a major decline in the use of long term care centres for people with light to moderate needs. Only those with high needs and an inability to manage in other settings would be cared for in continuing care facilities.

Appendix 2 shows the methodology for the development of the scenarios.

In June 1999, 140 participants representing regional health authorities, physicians, Community Health Councils, provincial government departments and provincial organizations involved with seniors and long term care reviewed the four scenarios and provided their advice on which scenario they preferred for the future.

Of the eight groups at the workshop, four groups selected Scenario 3. In their view, this "high shift" scenario was most consistent with seniors' expectations and their future preferences, it provides the most flexibility, and it is the most affordable and sustainable option.

Three groups selected Scenario 2. In their view, this option was more realistic in the timeframe. It enables seniors to maintain their independence for as long as possible, but it also better accommodates those with low physical and cognitive needs who may prefer the social aspects of a continuing care facility.

One group suggested we should move to Scenario 1 in the short term and Scenario 2 in the longer term. Their concern was with a "pent-up" need for continuing care beds in the current system.

The report, *Future Scenarios: Continuing Care Service Needs in Alberta,* provides a detailed assessment of the impact of moving to each of the four scenarios.

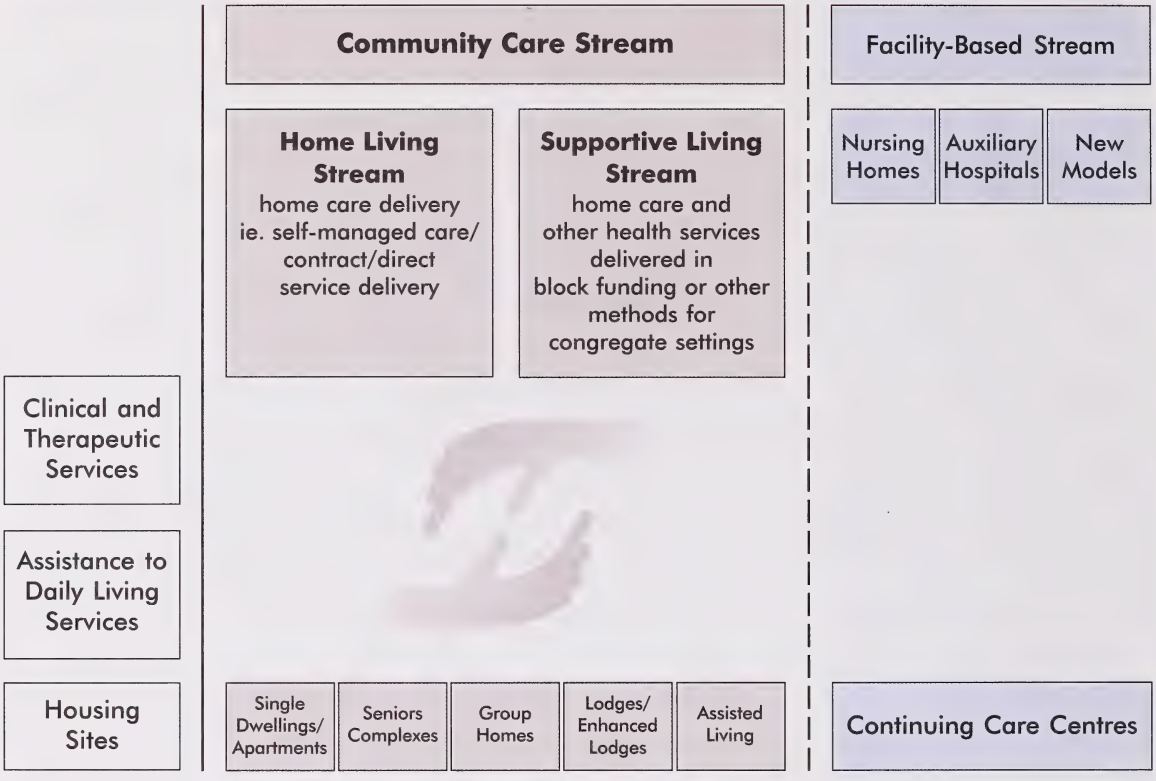
In summary ...

The Committee learned a great deal about how continuing care services currently are provided, the key issues people identified, what Albertans and various experts think should happen in the future, and trends around the world. Four scenarios for the future helped frame discussions about the directions we should consider in meeting people's continuing care needs. All of this information helped shape the Committee's recommendations, which are outlined in detail in Part Three of this report.

Appendix 1

Future scenarios for three streams of living

The Continuing Care Framework For Change



Source: Policy Advisory Committee, Long Term Care Review. 1998.

Features	Home Living Stream
Physical structural features	• Privately owned single dwellings, individual apartments or condominiums. • Person owns/rents the property and is responsible for purchase decisions affecting the property.
Acuity	• Light to moderate physical and cognitive needs.
Service requirements	• Wide menu of service options. • Case management available. • Public services available based on assessed need. • Service scheduled. • Variety of service providers. • Increasing demands for professional and personal care and home support services. • Increasing demands for social/recreational services. • Increasing demand for transportation • Access to respite, day care, palliative care.
Supervision and risk management	• Choice of monitoring available. • Choice of safety alert systems.
Average length of stay	• Increasing.
Availability of informal support	• More likely to have informal support.
Technological aids	• Focus on adaptive housing (may be quite costly), independent living aids, electronic monitoring.

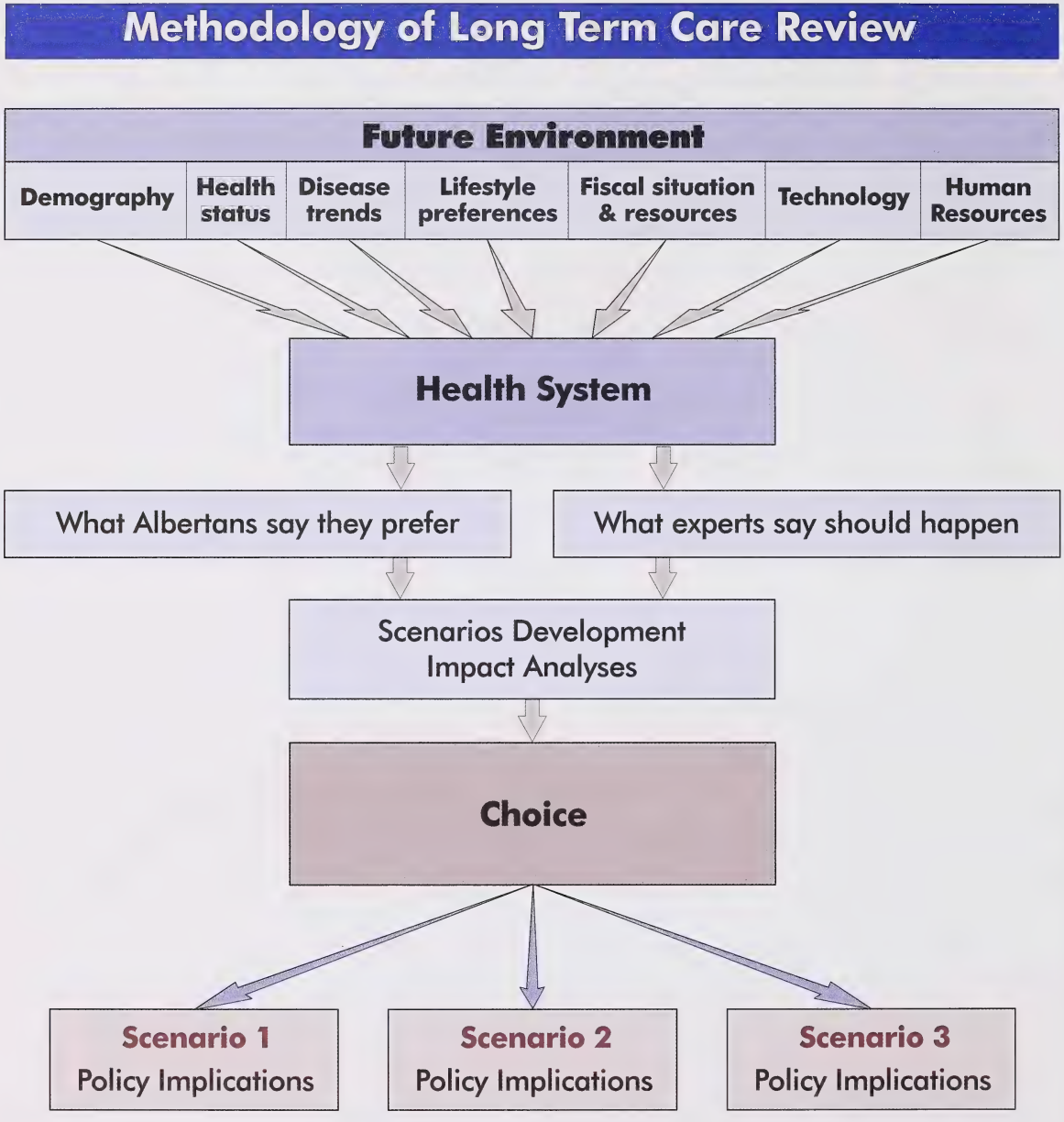
Features	Supportive Living Stream
Physical structural features	• Smaller group living settings that facilitate a sense of community within the larger community. • Converted apartments with services. • Adaptable/modular units that accommodate aging in place. • Specialized group living arrangements targeting specific client groups (diagnosis, ethnicity). • Increasing ownership options. • Increasing personalization of living space.
Acuity	• Light to moderate physical and cognitive needs.
Service requirements	• Wide menu of service options that tenant chooses. • Case management available. • Public services available based on assessed need. • May be limited service providers. • Service flexibility. • Increasing demands for professional and personal care within minimal demand for home support services (latter provided through housing operator). • Increasing demands for social/recreational services. • Increasing demands for transportation to access special health and social/recreational needs. • Access to respite, day care, palliative care.
Supervision and risk management	• Variable supervision from 24 hours per day, 7 days per week (e.g., housing operator), to on-call availability.
Average length of stay	• Increasing.
Availability of informal support	• Less likely to have informal support.
Technological aids	• Focus on adaptive housing and use of electronic monitoring aids.

Features	Facility Living Stream
Physical structural features	• Institutional settings that focus on optimal care environment and incorporate design elements to feel more "homelike." • Provisions for acutely ill residents but not requiring acute care or those who are recuperating to enable them to remain in place. • May be specialized care units.
Acuity	• High physical and cognitive needs.
Service requirements	• High levels of professional care, 24 hours per day, 7 days a week. • Increasing levels of specialized services. • More sub acute care needs. • Increasing environmental support needs.
Supervision and risk management	• Full professional supervision, 24 hours per day, 7 days per week.
Average length of stay	• Decreasing.
Availability of informal support	• Less likely to have informal support.
Technological aids	• Focus on professional care technologies.

Appendix 2

Methodology of Long Term Care Review

Figure 3



Source: Long Term Care Review Policy Advisory Committee